CHAPTER 7:

Case Management

Case management, as an accepted mental health treatment modality, developed largely in response to deinstitutionalization—the release of large numbers of persons with serious mental disorders from state hospitals in the 1980s. Community mental health centers were charged with developing methods for effectively treating and maintaining those who were released back to the community. In order to prevent frequent re-hospitalizations, it was often necessary to put in place a wide range of services to support the client in meeting basic human needs. While the resources—such as food, shelter, medical care, financial assistance—were often already in place in the community, staff with an understanding of serious mental illness and local resources were needed to link clients to services and to monitor treatment adherence and general functioning.

...a
service plan
based
on needs...

Due to the many concrete service needs of those living with HIV infection, case management has long been a cornerstone of HIV care. The Ryan White CARE Act has recognized the importance of case management and allocates a significant amount of its funding for case management. Today, as HIV increasingly moves into communities of poverty, a disproportionate number of persons who are homeless, have mental and addictive disorders, lack experience in accessing services, and/or who are in jails and prisons are affected. Given these trends, the need for case management becomes even more profound.

As the HIV/AIDS Mental Health Services Demonstration Program progressed, many of the 11 projects found themselves allocating more and more resources for case management, underscoring the growing need and demand for this function in assisting people living with HIV who also have mental and/or addictive disorders. This chapter describes the Demonstration sites' experiences in providing case management services to people living with HIV.

CASE MANAGEMENT ACTIVITIES

Assessing the client's needs. With input from the client, the case manager assesses the client's comprehensive biopsychosocial needs. The case manager's assessment will complement the clinical assessment referred to in Chapter 5, which needs to be comprehensive and thorough and take the needs of the whole person into account. In cases where the needs are immediate or urgent, the case manager must possess the judgment and skills necessary to make an emergency referral for food, shelter, psychiatric hospitalization, detoxification, or emergency room care.

Developing a service plan. Together, the client and the case manager develop a service plan based on the needs identified in the case manager's assessment. Encouraging the client to prioritize his/her own needs helps to establish trust between the client and the case manager. It also reinforces the client's sense of self-determination. The case manager needs to honor what the client sees as the priority. For example, the case manager may believe getting medical care for HIV infection is first on the list, while the client may be more worried about paying next month's rent. A written service plan—jointly agreed to and signed by the client and the case manager—is a useful instrument in establishing trust and setting service priorities. The agreement can serve as a valuable reference tool for reflecting back upon what has been accomplished and planning for goals not yet met.

Linking the client to services. Clients with HIV often need a broad range of services. These may include primary medical care, mental health and substance abuse treatment, financial assistance, housing, food, financial entitlements, clothing, transportation, child care, dental care, and legal services. Many clients need help in obtaining resources and/or connecting with services. The process of coordinating a broad range of health care and support services requires a case manager with creativity, negotiation skills, political savvy, and a knowledge of community resources.

In cases where the client is capable of accessing services, simply giving him/her a phone number may be sufficient help. If, on the other hand, the client has a serious mental illness, HIV-associated dementia, poor communication skills, or is unfamiliar with the service delivery system, the case manager may need to schedule appointments and accompany the client to the appointment. The case manager often serves as a "go-between" with the service provider when long and difficult forms must be filled out or when the client becomes tired or frustrated and unable to go through the cumbersome steps required to obtain the needed service. Case managers can make productive use of this time spent transporting or waiting with the client to build a positive therapeutic relationship and to engage him/her in mental health treatment. At the same time, the opportunity can be seized to nurture working relationships with other service providers to facilitate future referrals and collaboration.

Monitoring the client's progress. Since the client's biopsychosocial needs are dynamic and ever-changing, it is important for the case manager to regularly monitor the client's level of functioning and his/her progress. This monitoring includes assessing medication adherence and relapse prevention, reviewing the client's service needs, and refining the treatment plan. Since many clients' lives are dominated by chaos related to substance abuse, poverty, and the progression of HIV infection, the case manager's aggressive follow-up, outreach, and re-engagement efforts can be key to the client's length and quality of life.

...coordinating a broad range of health care and support services...

Advocating on behalf of the client. Persons with HIV face a broad range of stigmatizing attitudes and actions, stemming from society's response to the person's mental illness, substance use, HIV status, race, sexual practices, socioeconomic status, cognitive deficits, homelessness, and/or criminal record. When a door is shut, an opportunity is denied, or a right is violated, feelings of helplessness, hopelessness, and rage can take over. While the goal is to empower the client to advocate for himself/herself, the case manager has a responsibility to intervene when the client is unable to do so.

Examples of discrimination in emergency rooms, housing opportunities, and employment situations abound—as do examples of effective advocacy. While advocacy on an individual level is the immediate task, the dedicated case manager also keeps in mind his/her responsibility to advocate for change on a systems level so that institutionalized prejudice and discrimination against persons with HIV, mental illness, substance abuse, or members of a minority race, minority sexual orientation, or minority religion can be addressed. Effective advocacy on an individual and systemic level can positively affect the whole climate of future service delivery.

CASE MANAGEMENT TREATMENT PHASES

Case managers at the Alexandria project identified five phases of treatment in working with persons who are homeless and dually diagnosed with mental and substance abuse disorders (Alexandria Community Services Board, 1994).

- **The acute stabilization phase** *may require detoxification or hospitalization to stabilize acute medical or psychiatric symptoms.*
- **The engagement phase** *is the time during which the helping relationship is developed and basic services, such as food and shelter, may be provided.*
- **The persuasion phase** *occurs when the case manager encourages the "engaged" client to recognize and accept the need for treatment.*
- **The active treatment phase** *is the stage during which the client develops the attitudes, behaviors, skills, and determination to accept treatment and does so.*
- **The relapse prevention or rehabilitation phase** *is when the client develops a greater sense of mastery over his/her disorder(s) and exhibits greater competence in functional and social capabilities.*

Elijah's Story

In recovery from a crack cocaine habit for almost three years and climbing steadily up from a major depression, Elijah faced eviction from the small apartment where he lived with his teenage son. Savings from occasional jobs had supplemented his meager veteran's disability pension, but now a rent increase forced him to look for subsidized housing. His mental health worker had identified an apartment in a well-kept building in a safe neighborhood where another of her clients lived. She had dealt with the landlady before and set up an appointment to look at the apartment.

The moment the white landlady laid eyes on the dark-complected Elijah, she began to make excuses. "Someone in the building has just asked if he could move to a two-bedroom, so I have promised it to him. I'm sorry, but the apartment is no longer available." Elijah immediately became agitated. A sensitivity born of countless encounters with subtle—and not-so-subtle—race discrimination left no doubt in his mind about the motivation of the woman standing before him. "I'll never get this apartment," Elijah mumbled to his worker. "Let's get out of here." Herself Hispanic and a woman of color, the worker also picked up the vibes. Returning to the office in anger, she spoke with her supervisor and colleagues, relating the experience and its impact on Elijah.

The HIV team immediately took action. A team member called to inquire about the apartment's availability and was told she could come to see it in the morning, providing sufficient evidence to call the Housing Authority to register a discrimination complaint. "We'll investigate right away." The mental health worker, realizing she might need to deal with the landlady in the future, called her and diplomatically expressed her puzzlement and dismay at Elijah's being turned down and hinting at discrimination. The landlady vehemently denied she had been discriminating, but lo and behold, the upstairs neighbor had changed his mind about moving into a two-bedroom apartment. Elijah and his son got their clean, new apartment.

In this true case of discrimination, successful advocacy had a beneficial impact on both the individual and the system.

CASE MANAGEMENT PROVIDERS AND SETTINGS

Because the need to link persons with HIV to a spectrum of resources and services is readily apparent, a range of disciplines and persons with varying levels of education and skill have felt called upon to provide case management when necessary—from psychiatrists and psychologists to social workers, counselors, case aides, and peer providers. With the need for case management increasingly being recognized by many health fields, specialized forms of case management have developed in mental health, public health nursing, social services, and substance abuse.

The level of training, education, and skill required to be an effective case manager often is underestimated. To work effectively with clients who are triply diagnosed with HIV, mental illness, and a substance use disorder, a master's degree in a human services field is highly desirable. An effective case manager brings a broad range and high level of skills and/or natural ability to his/her work, including an ability to establish rapport, to understand the client's biopsychosocial needs, and to know the resources that are available in the community. He/she must possess determination, persistence, advocacy skills, empathy, and tact. In the field of behavioral sciences, increased recognition and credit is being given to case managers and the important work they do.

With many case managers working in mental health centers, medical clinics, substance abuse programs, and AIDS service organizations, service duplication and gaps can become problematic. Coordination of services among providers through establishing clear, individual responsibilities is necessary to make the most efficient use of limited resources. Designating a "primary case manager" and holding periodic "prescription team" meetings in which all providers and the client are present is useful in providing quality care. (See Chapter 4 on Mental Health Services.)

Case management can be provided with varying degrees of intensity. Working with persons who are triply diagnosed and also homeless or recently incarcerated requires a high level of assistance or intensity—and a correspondingly smaller caseload. A high-functioning client may need assistance in accessing HIV or mental health resources from time to time but is generally capable of navigating the system on his/her own with little outside help.

...targeted, strategic approaches...

BUILDING A STRONG HELPING RELATIONSHIP

At the heart of effective case management is a strong, trusting, and collaborative helping relationship. Working with an HIV-affected population that is increasingly disenfranchised, stigmatized, and alienated from society requires special skills and a special attitude on the part of the case manager. Efforts to engage and retain the client in service often require targeted, strategic approaches. Meeting the client on his/her own turf and hiring culturally sensitive and street-wise outreach workers who establish contact and serve as a bridge between the client and the provider can significantly improve engagement and retention rates. Many clients feel degraded by their present circumstances and have felt rejection from their family, their church, and their peers. Experiences in dealing with "the system," including the criminal justice system and recovery programs often have been negative and disempowering. At times suspicious of others, disorganized in their thoughts, and/or in denial about their HIV status or substance abuse, many view the case manager reaching out to help with profound distrust.

In developing rapport and trust with the client, the Demonstration sites found the following approaches effective:

- Focus efforts on the person's skills, strengths, and potential, as well as his/her capacity to change or improve his/her quality of life.
- Solicit and encourage client self-determination in setting priorities for obtaining services.
- Remain consistent, flexible, nonjudgmental, positive, and helpful.
- Accept the person for who he/she is.
- Be patient in all interactions with the client. Be readily accessible when needed by the client. Avoid demanding too much too soon.
- Respect the person's need and right to decide when and how he/she will accept help.

BARRIERS TO EFFECTIVE CASE MANAGEMENT

Barriers to obtaining needed services, treatment, and interventions exist for both the client and the provider. The effective case manager is presented with the challenge of using ingenuity, creativity, and people and problem-solving skills to overcome these barriers with and on behalf of the client. In the course of their work, the 11 Demonstration projects encountered, identified, and overcame many such barriers at both individual and systemic levels. Possible ways to address and minimize these barriers are discussed throughout this Guide.

Barriers Faced By The Case Manager

- Personality or value conflicts among service providers
- Ethical issues related to disclosure and "duty-to-warn"
- Difficulty maintaining professional boundaries with clients
- Lack of adequate resources to meet client needs
- Restrictions on the number of days allowed for hospitalization or treatment
- Bureaucratic red tape preventing quick responses
- Discrimination against client population
- Client expectations and demands that are unrealistic or cannot be met

Barriers Faced By The Client

- Distance from needed services and providers
- Unduly cumbersome application and referral processes
- Lack of transportation to and from appointments
- Lack of child care while keeping appointments
- Distrust of the service system
- Fear of confidentiality violations
- Social stigma and discrimination
- Cultural insensitivity and language barriers